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Dermatology Coding Alert

Denials Management: 4 Tips Set You on Course for MUE Appeals Success

Don't fall victim to the ABN myth.

If you think medically unlikely edits (MUEs) don't apply to your practice, think again. The edits, which are designed to prevent overpayments caused by gross billing errors, can affect any practice. When you scour your unpaid claims make sure you are watching for MUE denials, which are usually a result of clerical or billing systems' mistakes, often confuse even veteran coders.

Ensure you're not letting MUEs cost your practice money by following four tips about these edits.

Get to Know What MUE Edits Mean

While you shouldn't stress too much, any practice filing a claim with Medicare should know what MUEs are and how they work. "They limit the frequency a CPT® code can be used," says **Chandra L. Hines,** practice supervisor of Wake Specialty Physicians in Raleigh, N.C. "We need to become aware of the denials and not let every denial go because the insurance company said it was an MUE. We should all be aware of MUEs as they occur**,** and we cannot always control whether or not we will receive payment."

The MUE list includes specific CPT® or HCPCS codes, followed by the number of units that CMS will pay. CMS developed the MUEs to reduce paid claims error rates in the Medicare Program, says **Jillian Harrington, MHA, CPC, CPC-P, CPC-I, CCS-P,** president of ComplyCode in Binghamton, N.Y. "The first edits were implemented in January 2007, although the edits themselves became public in October 2008," she adds.

Some MUEs deal with anatomical impossibilities while others edit automatically the number of units of service you can bill for a service in any 24-hour period. Still others limit codes according to CMS policy. For example, segmental Doppler waveform analysis of both the lower and upper limbs (93923) has a bilateral indicator of "2," so you should not bill two or more units of this code. Additional edits focus on the nature of the equipment for testing, the study or procedure, or pathology specimen.

Anatomical example: The MUEs edit out and deny an erroneously coded claim for a hysterectomy (for example, 58150, Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) for a male patient.

Unit of service example: The edits also limit the claims for codes such as 99462 (Subsequent hospital care, per day, for evaluation and management of normal newborn) to a single unit per calendar day. This makes sense because 99462 is a "per day" code.

Note: While CMS updates the MUE list every quarter, just like the Correct Coding Initiative (CCI) edits, it does not publish all MUEs. Remember that CCI doesn't actually institute MUEs; CMS does. CCI edits relate to code pairings (whether two codes can be billed together), says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPCP, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. The published MUE list consists of most of the codes with MUE values of 1-3, but CMS does not publish all MUE values that are 4 or higher.

You can find the published edits on the CMS Web site. You can find a link to the MUEs and the MUE FAQs at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html.

Skip the ABN

Some practices believe that by having the patient sign an advance beneficiary notice (ABN) they can pass on the cost of procedures they know will be denied due to MUEs.

Reality: You cannot use ABNs to transfer responsibility for payment to the beneficiary, Harrington warns. Even if you have the patient sign an ABN, you cannot pass on the cost of procedures you know will be denied due to MUEs, Cobuzzi agrees.

CMS makes this rule very clear in its FAQs (http://questions.cms.hhs.gov), stating: "A provider/supplier may not issue an ABN for units of service in excess of an MUE. Furthermore, if services are denied based on an MUE, an ABN cannot be used to shift liability and bill the beneficiary for the denied services. It is a provider/supplier liability."

Override an MUE in Some Cases

Don't think that even if your physician performs a legitimate, medically necessary procedure that violates MUE edits, you can't override the edits.

Reality: CMS states that MUEs reflect the maximum number of units the vast majority of properly reported claims for a particular code would have, so you shouldn't need to override them often. But you can override an MUE when your physician performs and documents a medically necessary number of services that exceed the limit. Check your payer's reporting preference.

How it works: HCPCS offers modifier GD (Units of service exceeds medically unlikely edit value and represents reasonable and necessary services). But there is little information available on proper use of this modifier.

A CMS FAQ states that "since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT®) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value."

CMS notes that modifiers 76 (Repeat procedure by same physician) and 77 (Repeat procedure by another physician) are among your options, as are the anatomical modifiers, such as RT (Right side) and LT (Left side). You may also use modifier 59 (Distinct procedural service), but Harrington cautions you to use this only if no other modifier is appropriate.

You also may need to supply documentation showing medical necessity for the additional units.

Appeal, and Appeal Again

If you receive a claim denial due to MUEs, you can appeal. "You can appeal the claims and you can address inquiries regarding the rationale for an MUE," Hines says. The caveat: "You may not receive the answer you want, and it will take a while to receive your response," she adds.

"I would add that if the practice does not agree with the MUE, and can support their coding and billing, I would recommend appealing," Cobuzzi says. "They will probably lose at the first level, Redetermination, but if they have a good case with good clinical documentation, there is a good chance that the practice might win at the Reconsideration or Administrative Law Judge level of appeal."

You should follow three steps during the appeals process:

Step 1: Determine the reason for the denial. First, figure out if you made a coding or billing error. If you find a coding error such as the wrong number of units entered in the units box submit a corrected claim. If you don't find a coding or billing error, move on to the next step.

Step 2: Decide if you have a legitimate reason to appeal. If you believe there is medical necessity for the services over and above the allowable under the MUE, you should appeal to the contractor. "If there is no medical necessity, take a look again at coding," Harrington says. "Make sure service is coded properly, and appropriate modifiers have been assigned."

Step 3: Appeal the claim. File an initial appeal with your carrier and follow the standard five-level Medicare appeals process. "If appealing the claim due to a clinical reason, you may wish to employ clinical expertise when putting together your appeal letter," Harrington suggests.

Tip: "Just because you win an appeal, you will not change the MUE edit," Cobuzzi warns. "To get it changed, you need to go to your CAC (Carrier Advisory Committee) and your payer's medical director and try to get the MUE edit changed. Winning some appeals with a terrific clinical case and documentation provides a good foundation to go to the CAC and the medical director to try to get the MUE edits changed."